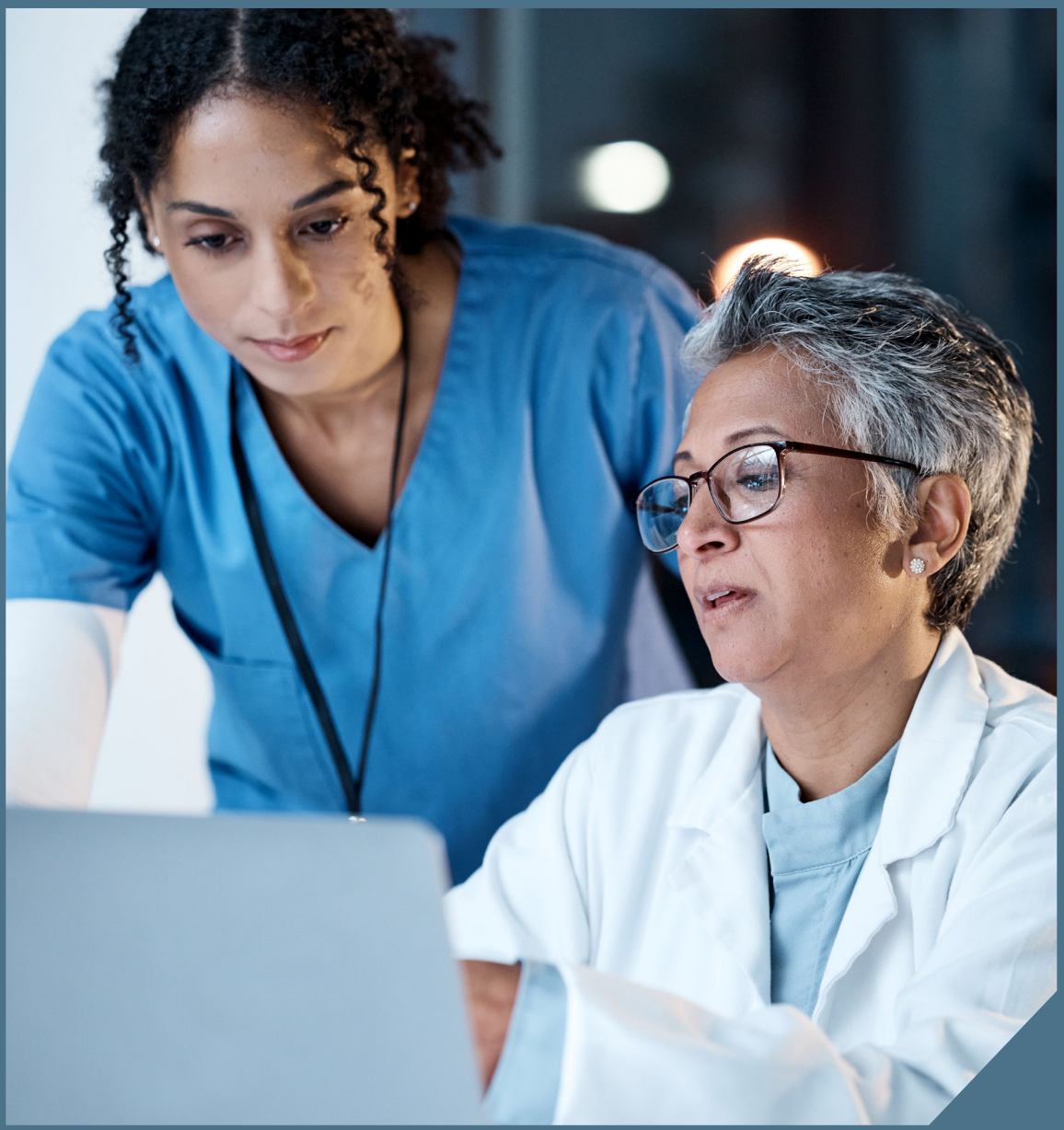
# Prior Authorization Requirement Search and Submission

## A guide for providers



G.E.H.A Government Employees Health Association

# Look inside...

**Purpose:** To determine whether a prior authorization (PA) is required, or a pre-determination is recommended for a specific member and service on a specific date, and if it is being performed by a specific provider.

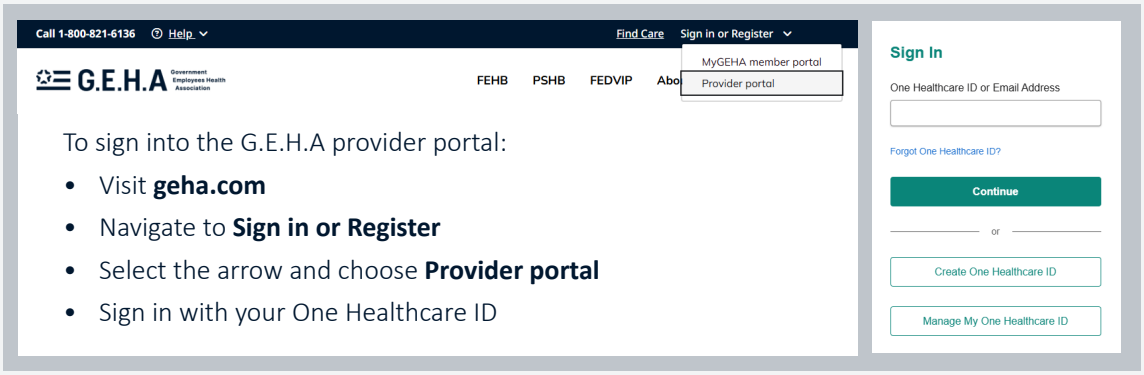
Our online prior authorization requirement search tool is designed to provide you with plan-specific requirements for services. Specifically, the tool will:

- Indicate whether prior authorization or medical necessity review are required
- Indicate whether other criteria might be relevant to the prior authorization requirements, such as place-of-service criteria

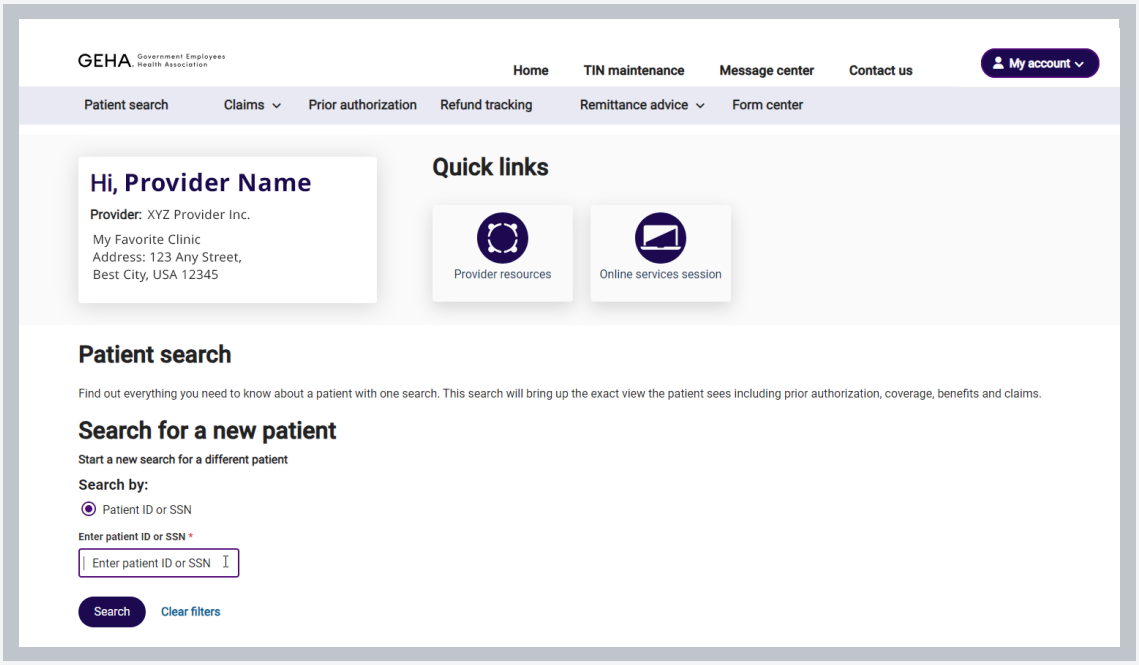
If further action is required, such as obtaining a prior authorization, the tool will store the information provided during the initial requirement search. Then, it will prompt the user to enter any additional information required to process the request. Such as:

- Additional procedure or diagnosis codes
- Clinical documentation
- Length of request
- Treatment type

# Accessing the tool

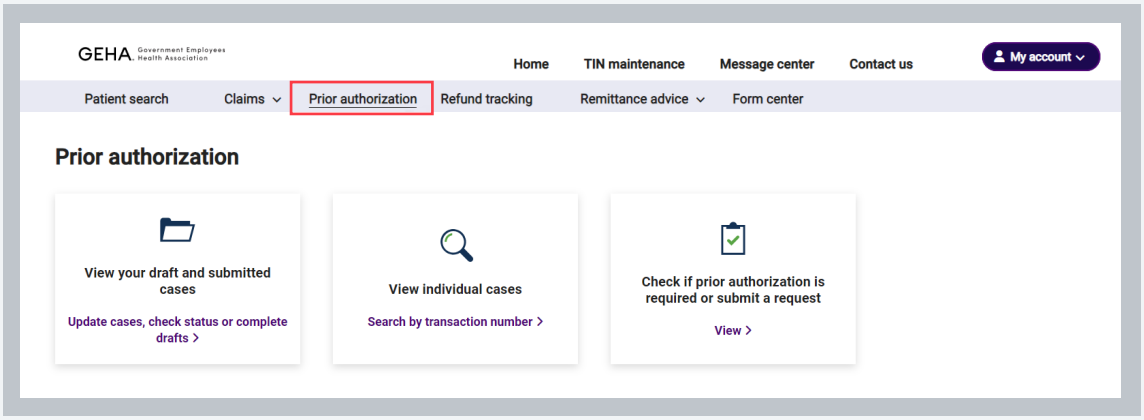



Once your One Healthcare ID is authenticated, you will be taken to the provider home page.



# Provider prior authorization page

To search for an existing prior authorization request, select **Prior authorization** from the navigation bar. On the Prior authorization page, select from the following actions.

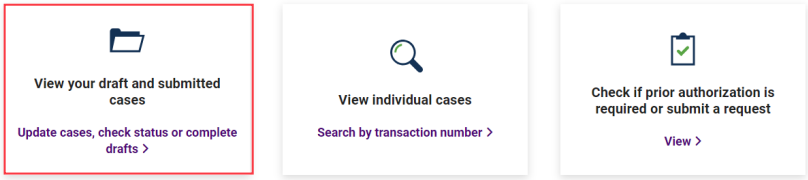



- **View your draft and submitted cases** — view the status of submitted cases, take action, update an existing case or finish a previously saved (draft) transaction
- **View individual cases** — retrieve the results of a previous requirement search using a transaction number
- **Check if prior authorization is required or submit a request** — enter criteria to begin a new requirement search

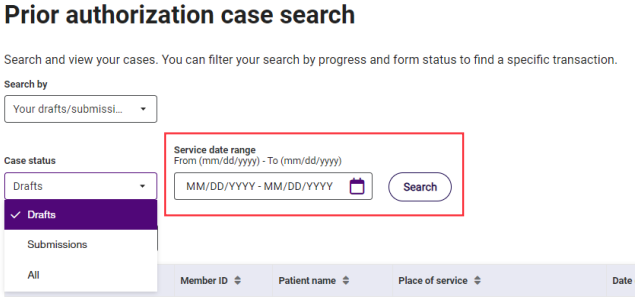
# View cases for a specific patient

Select **View your draft and submitted cases** to do the following for a specific member:

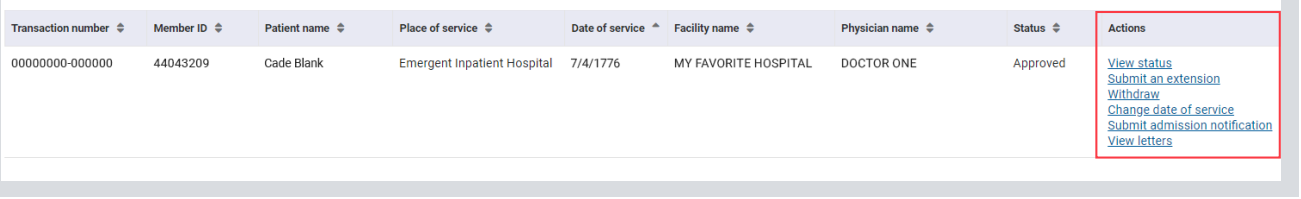
- View the status of submitted cases
- Take action or update existing cases
- Finish previously saved transactions




To modify the Service date range, choose a date from the calendar icon or type in a date using the MM/DD/YYYY format. Select **Search** to update the results with your desired date range.

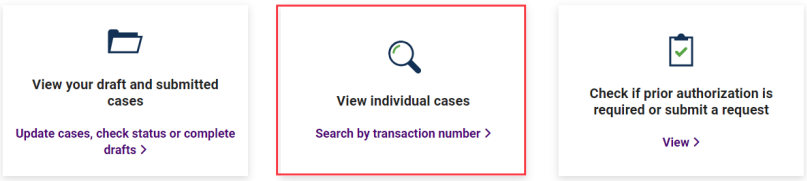



Under the **Actions** column, choose any link to navigate to that action. Note: The actions listed are dependent on the case status and will vary.

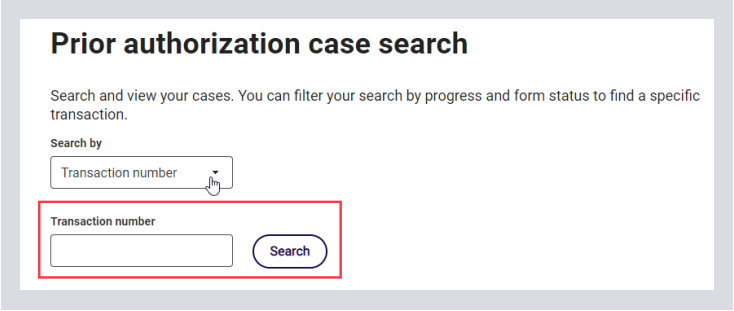


# How to view individual cases

On the Prior authorization page, choose **View individual cases** to find and view previous requirement search results using a transaction number.

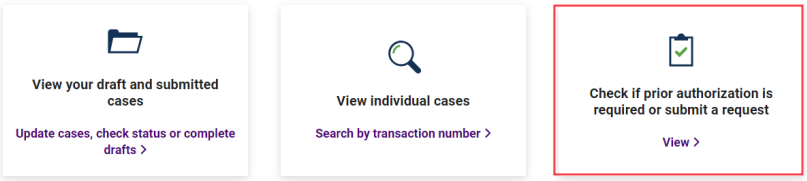



- Select **Transaction number** under Search by
- Enter the transaction number in the free text box
- Click **Search**



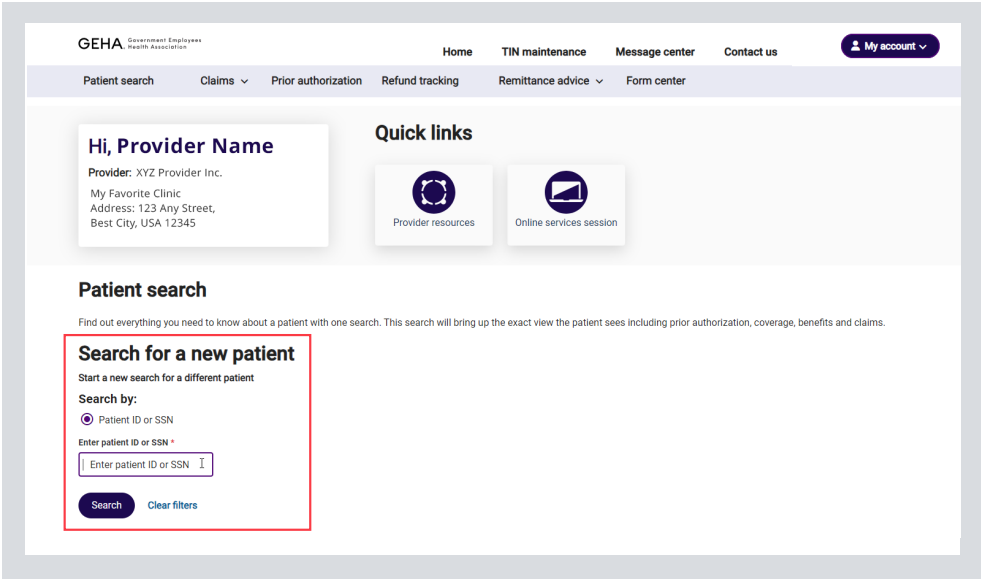
# Start a new requirement search, submission or request

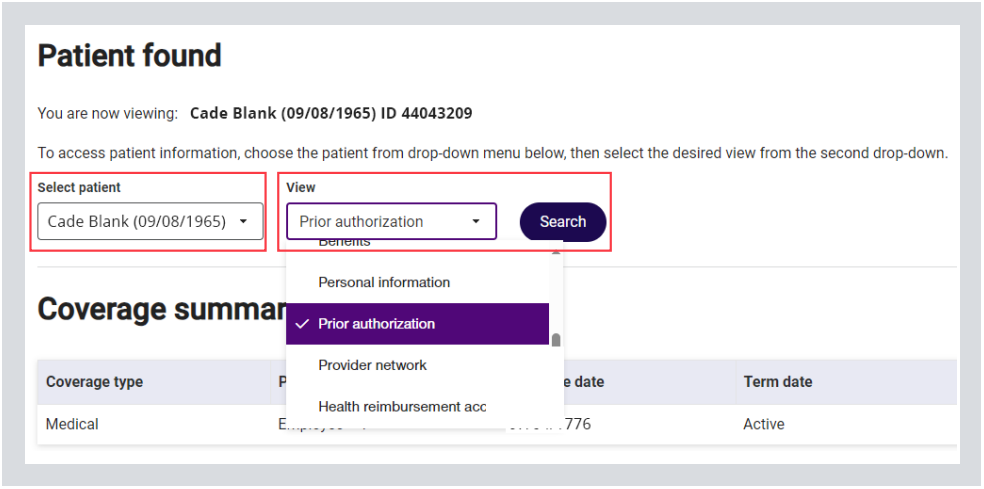
Selecting **Check if a prior authorization is required or submit a request** will take you to the Patient search tool found on the provider home page.




On the Provider home page, you can Search for a new patient to submit a new request or perform a search to see if there are plan-specific requirements for services.

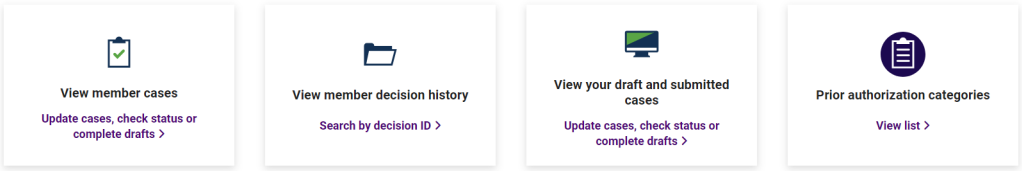
- Enter the **patient ID or Social Security Number (SSN)**
- Click **Search**
- Choose the desired patient under **Select Patient**
- Click the arrow under **View** and choose **Prior authorization**
- Click **Search**



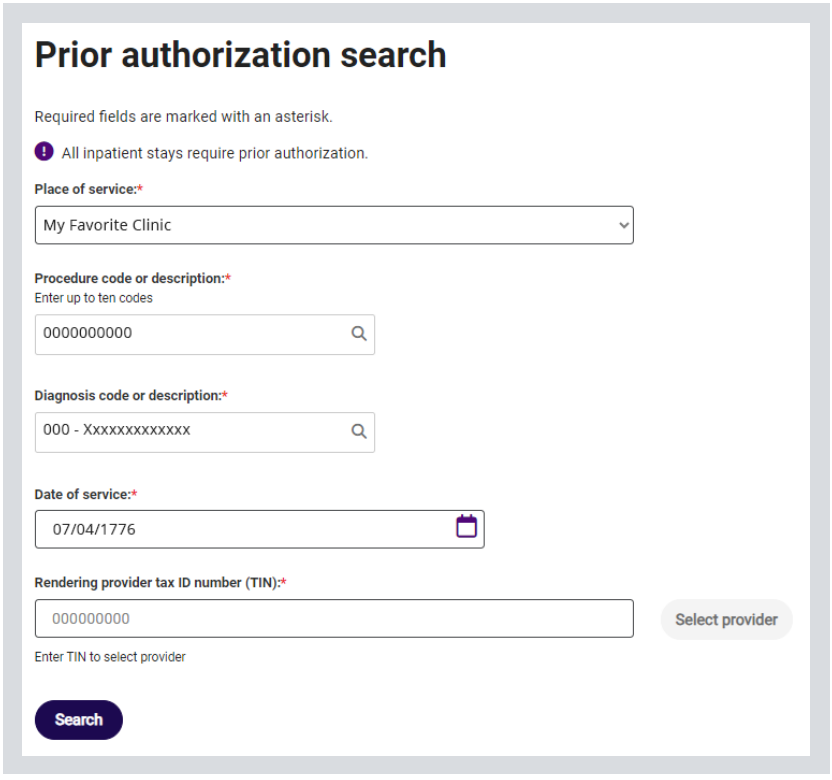
# Member-specific requirement search criteria

A member-specific search enables various actions:




- **View member cases** — view the status of submitted cases, take action, update an existing case or finish a previously saved (draft) transaction for that specific member
- **View member decision history** — retrieve the results of a previous requirement search using a decision ID for that specific member
- **View your draft and submitted cases** — update, check status or complete drafts of any cases previously created by you
- **Prior authorization categories** — retrieve high-level plan requirements in list form for that specific member.

Use the Prior authorization search to perform a requirement search for that specific member.

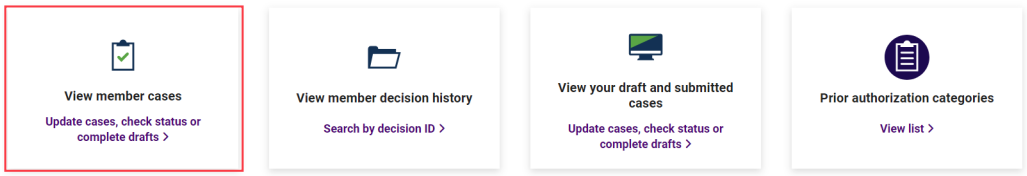


## Member-specific requirement search criteria

# View member cases

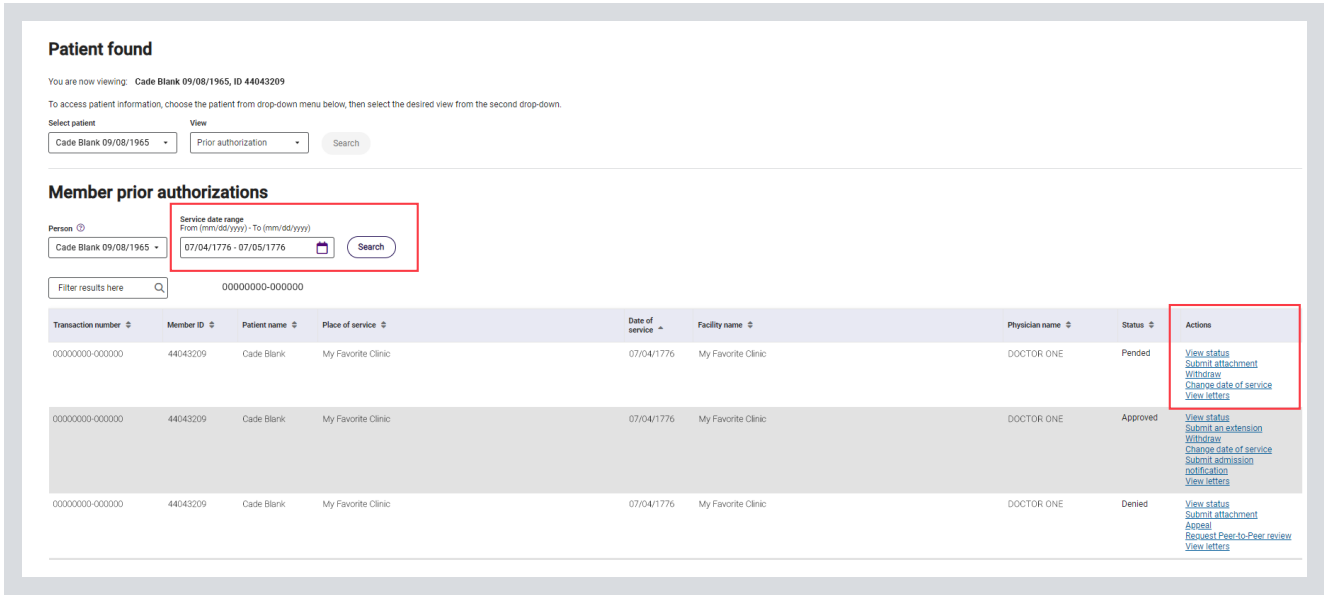
Select **View member cases** to do the following for a specific member:

- View the status of submitted cases
- Take action or update existing cases
- Finish previously saved transactions




Select the calendar icon to populate date of service or enter date using the MM/DD/YYYY format. Select **Search** to update results for the desired date range.

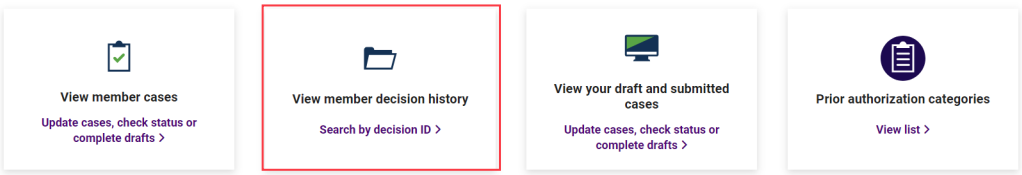
In the **Actions** column, the actions that are applicable to each case will be displayed.



## Member-specific requirement search criteria

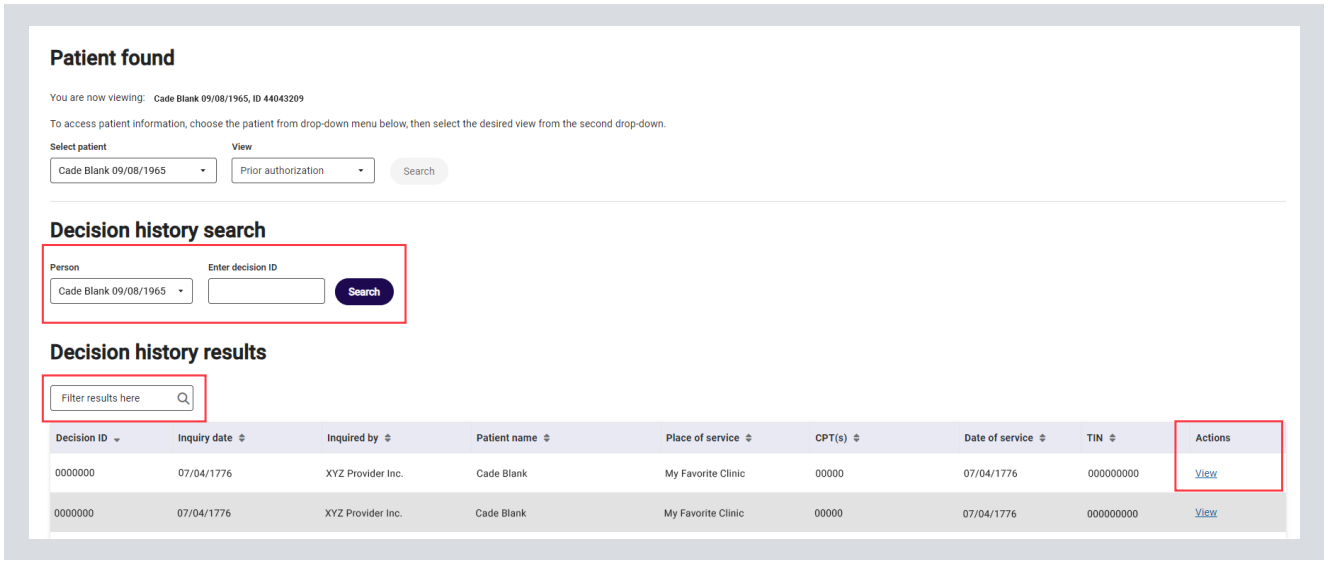
# View member decision history

Select **View member decision history** to find and view previous requirement search results for a member.




The decisions previously rendered for this member will be populated in the results. To narrow down results, enter the decision ID or use the Filter results here to filter by procedure code, date of service, etc.

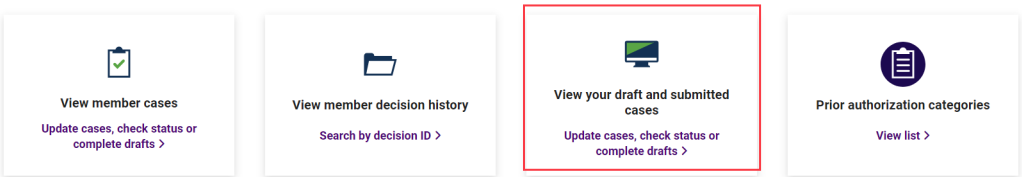
Select **View** to retrieve the search criteria and results from the requirement search.



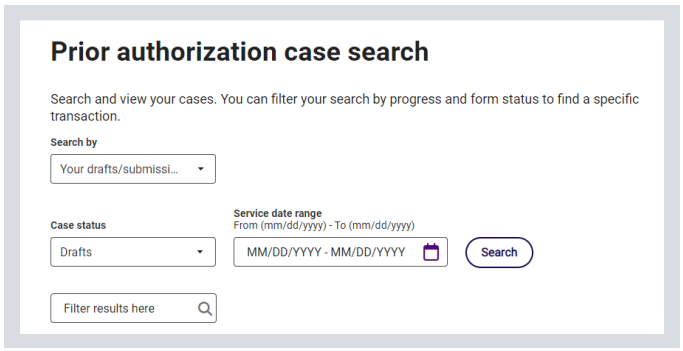
## Member-specific requirement search criteria

# View your draft and submitted cases

Select **View your draft and submitted cases** to find and view draft cases and submissions.



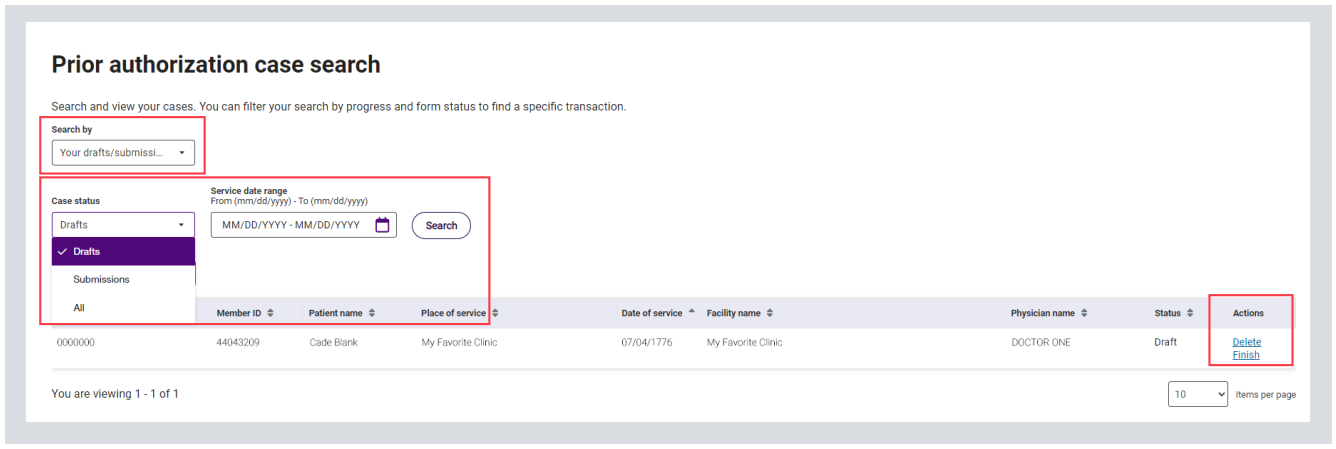

At default you can search for cases by status and date range.




To narrow results displayed:

- Use the **Filter results here** search against any criteria listed on the dashboard
- Select a specific **Case status** from the drop-down menu
- Enter a **Service date range**
- Click **Search**

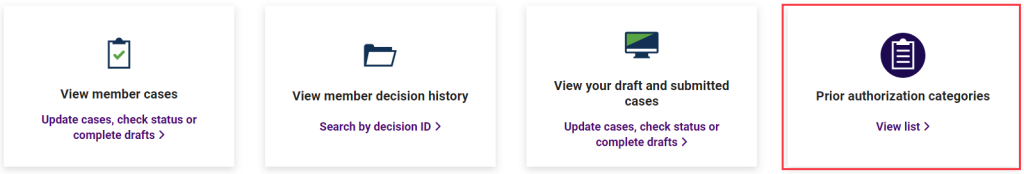
The **Actions** column provides links to the applicable actions that can be taken on the draft or submission, such as delete or finish.



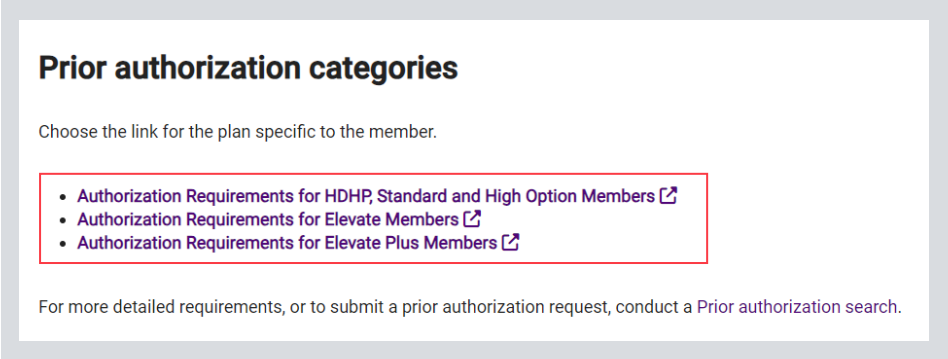
## Member-specific requirement search criteria

# View prior authorization categories

Choose Prior authorization categories to access high-level plan requirements for the member.




Select the link next to the appropriate plan. A separate window will pop-up listing the requirements for that plan.




## Member-specific requirement search criteria

# Attaching clinical documentation

To add clinical supporting documents with an overall case status that is:

- Pended
- Partial
- Denied
- Draft

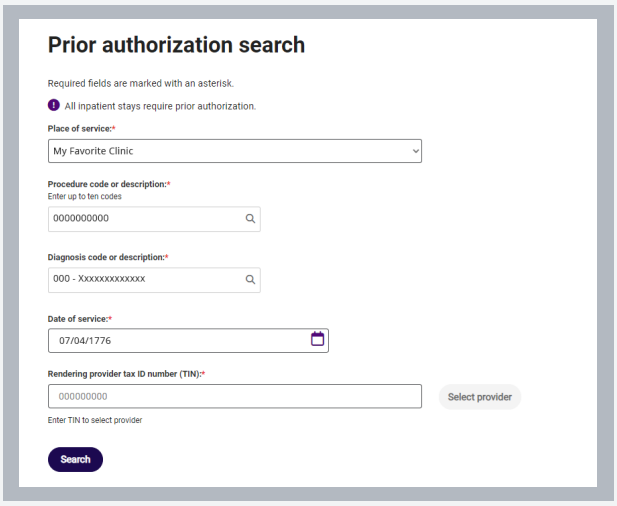
Use the following actions:

- Submit attachment
- Submit an extension
- Finish

# Perform a new search

Under **Prior authorization search**, the following criteria are required (marked with an asterisk) to determine plan-specific requirements for services:

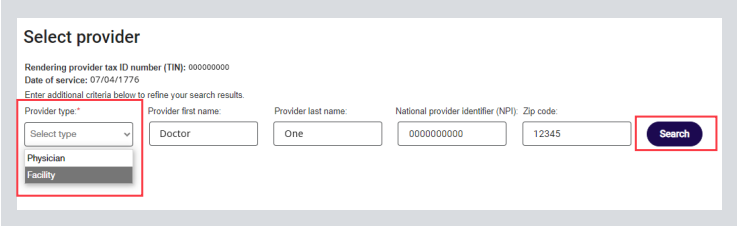
- Place of service
- Procedure code or description (HCPCS, CPT or description of service)
  **Note:** Up to five codes can be entered during the initial requirement search
- Diagnosis code or description with decimal after the third character (e.g., XXX.XX)
- Date of service (use today's date if unknown)
- Rendering provider tax ID number (TIN)




## Perform a new search

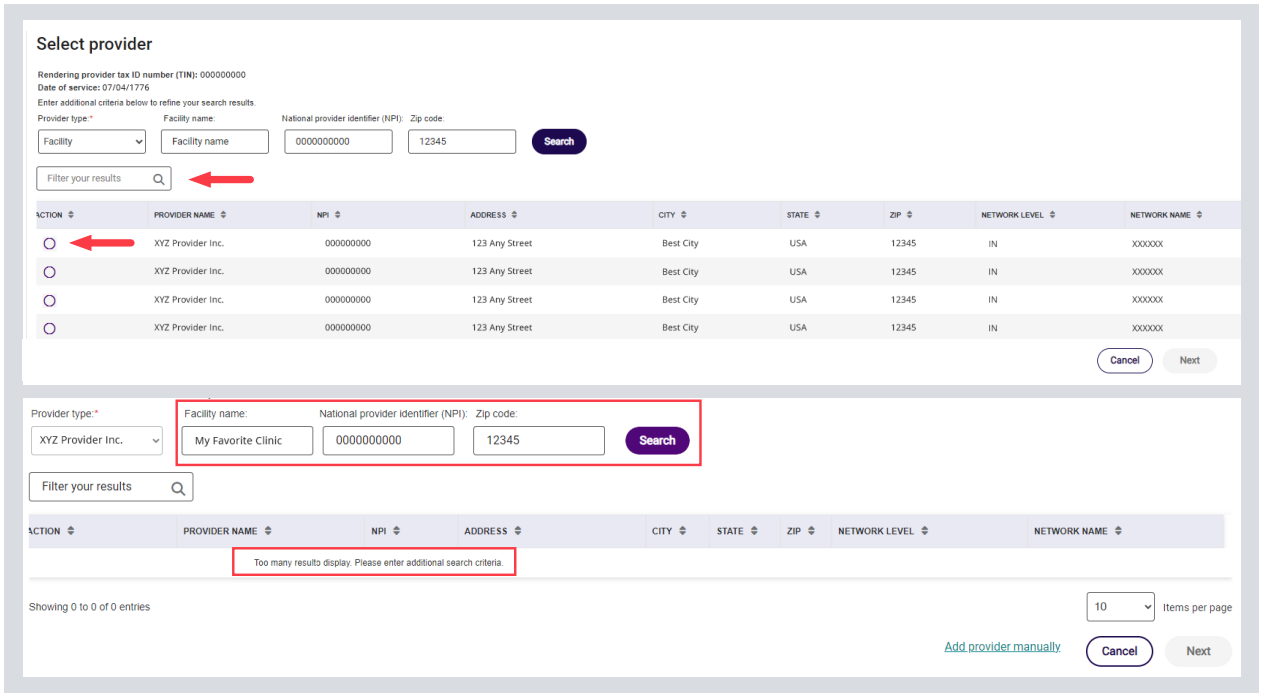
# Provider search and selection

- Enter a valid tax ID number (TIN) and choose **Select provider**
- Under **Provider type**, select **Physician** or **Facility**
- Enter additional search criteria and click **Search**
- Choose a provider and select **Next**




**Note:** If you don't see the correct provider listed, you can modify the criteria and search again or select **Cancel**. The **Filter your results** box can be used to quickly search long lists.

- If no provider results are displayed along with the error message "**Too many results**," the search isn't narrow enough. You must include additional search criteria then select **Search**.



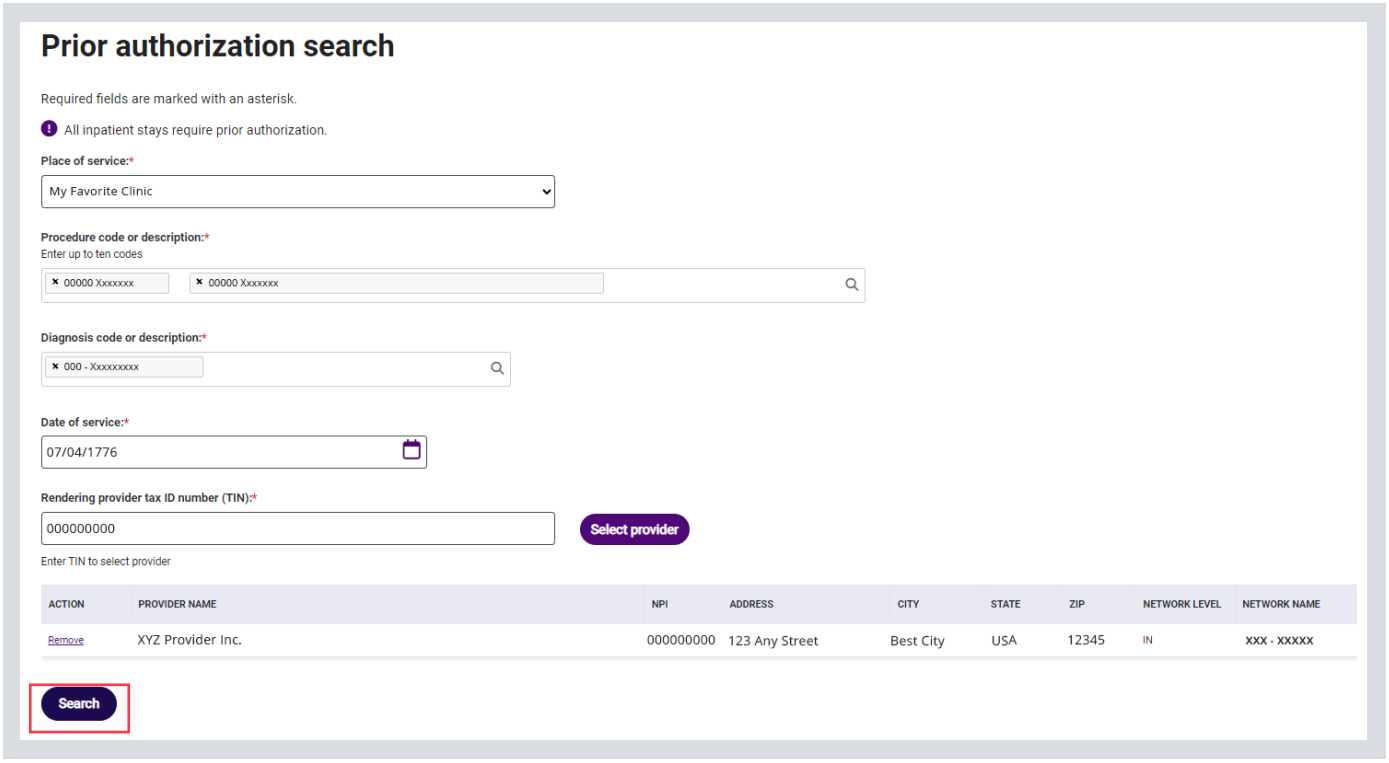
Perform a new search

# Perform requirement search

When the desired search criteria have been entered, review the details for accuracy and modify fields as necessary.

**Note:** If applicable, additional procedure and diagnosis codes can be entered during the submission process.

When you are satisfied, select **Search** to view results.



# Interpreting requirement search results

Based on the search criteria entered, the basic information of this tool will display one or more of the following options:

- Prior authorization is required
- Medical necessity review needed/predetermination recommended
- No coverage for this service
- No requirements for the procedure code

The requirements displayed on the Prior authorization search results page will be listed by section with results further separated by Tier, if applicable. Results related to the procedure code will be displayed near the top, followed by other factors that may apply, such as place of service, etc.

## Interpreting requirement search results

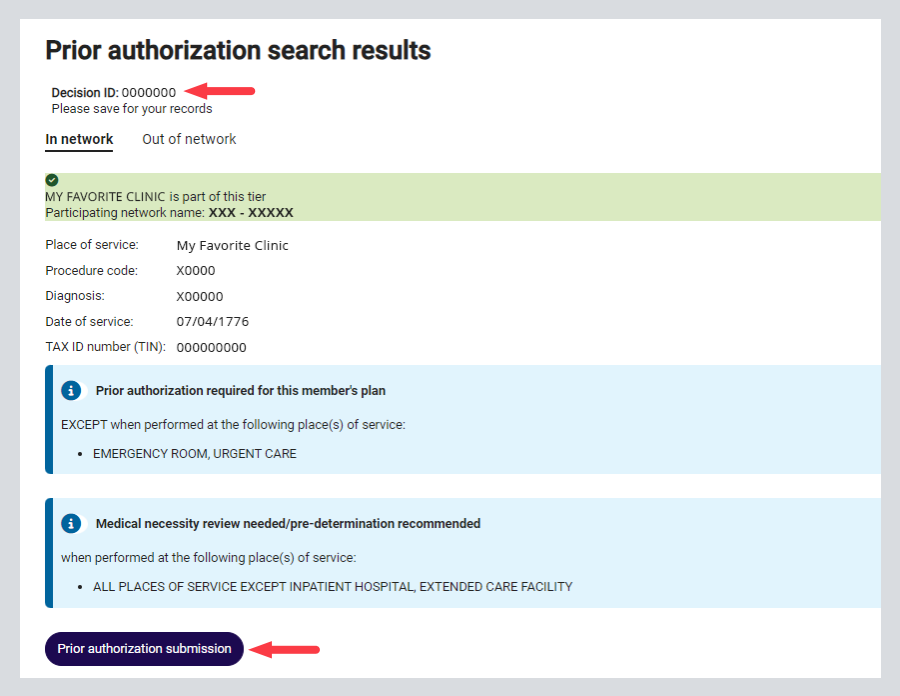
## Decision ID

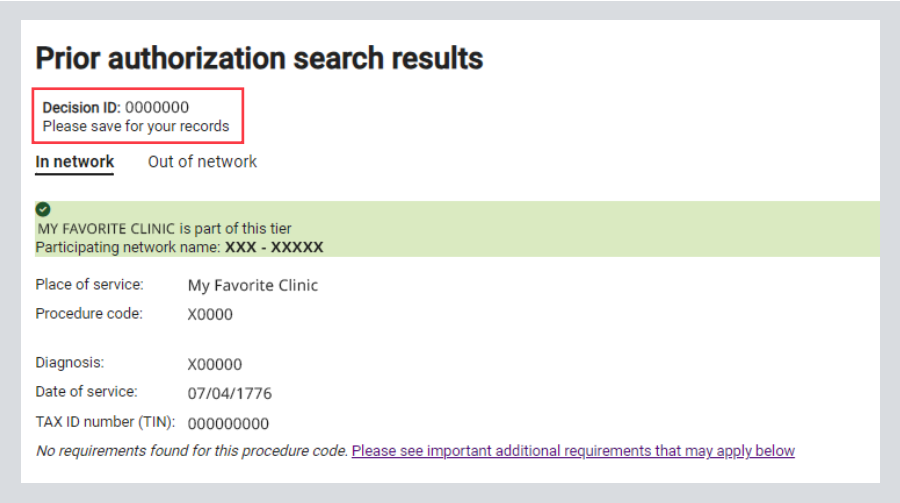
A **Decision ID** is displayed after each requirement search. When the search produces a result that indicates no further action is required, the Decision ID should be stored for your records.

If requirements apply, users will select the appropriate action button to navigate to a screen where additional information will be collected to process the request. A new ID number will be provided when submission is complete.

When requirements apply an action button is generated and you should proceed with submission as necessary.

If no action button is generated then no further action is required. Simply store the Decision ID.



Interpreting requirement search results

# Color-coded page sections

It is important to scroll through all results to determine which apply to the situation.

Color-coded page sections indicate the following:

| If you see | It means |
|---|---|
| Orange box with text | Applies to the specific criteria entered with no other conditions to consider |
| Blue box with text | Applies to the specific criteria entered with additional conditions for users to review |
| Gray box with text | Additional information that might apply – a user must review to determine if the result applies to the situation based on criteria other than CPT code or diagnosis (such as place of service,etc.) |

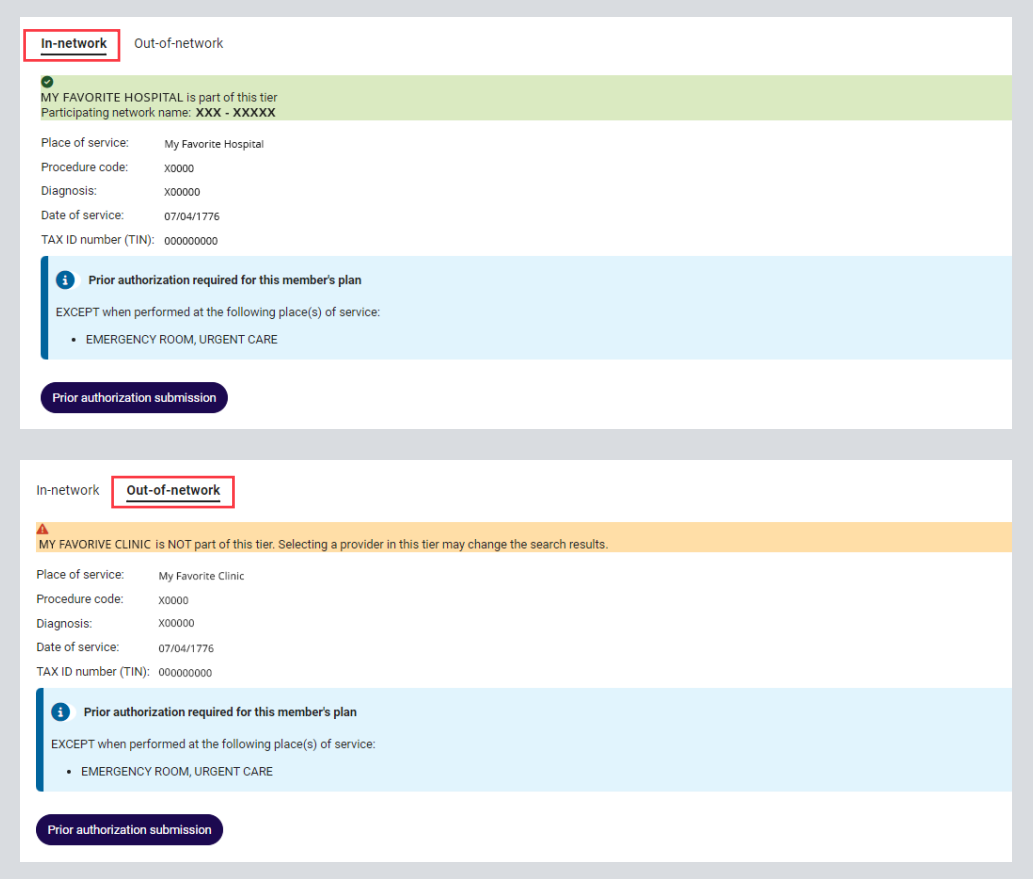
Interpreting requirement search results

# Network tabs

When provider criteria is included in the requirement search, the results displayed will default to the appropriate Network tab related to that provider.

**Note**: If no provider is included in the requirement search, the results will default to the In-network tab.

To view requirements for other tiers, click on the desired tab.



Interpreting requirement search results

# Code-based and conditional requirements

You may also see the result:

*No requirements found for this procedure code.* ***Please see important additional requirements that may apply below.***

This means that the procedure code entered is not found in the member's prior authorization requirements, but other **Important additional requirements** are shown further down the page that may apply.

**Important:** The Important additional requirements section should be evaluated any time it is displayed.

This section displays **requirements that may be relevant, other than those based the CPT code.**

**Note**: Including a diagnosis code in the initial search or searching by the diagnosis code in the **Filter your results** field may narrow down some of the information displayed in this section. When a combination of results are returned, follow the chart below.

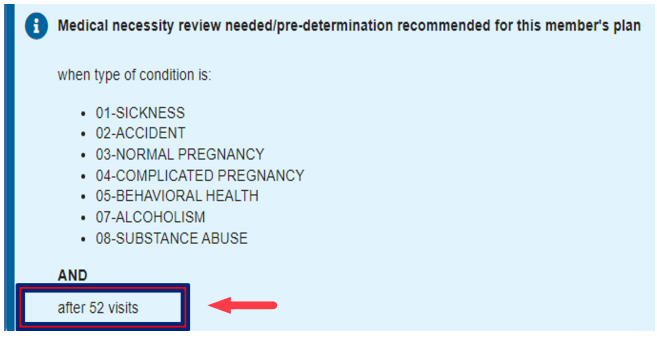
| If you see | and | It means |
|---|---|---|
| Prior authorization | Medical necessity/pre-determination | Prior authorization is required |
| Prior authorization | No coverage | There is no coverage for this service |
| Medical necessity/pre-determination | No coverage | There is no coverage for this service |

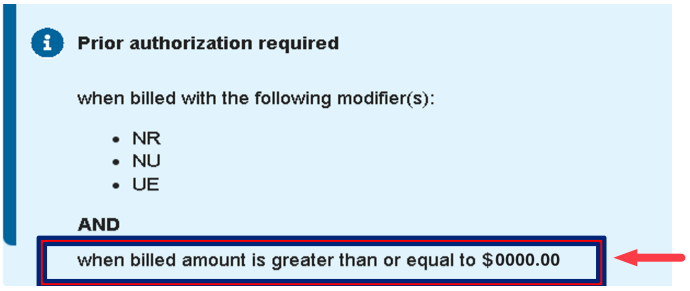
Interpreting requirement search results

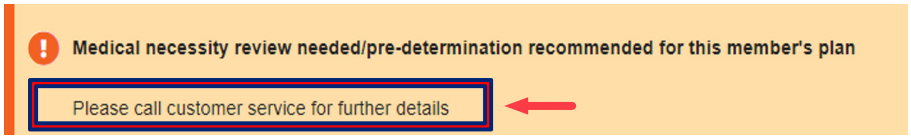
# Other conditional requirements

Some results are dependent on factors such as patient age, dollar amount or visit threshold.

In some instances, a call to Customer Care will be suggested.

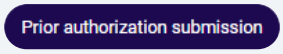


# Submitting a request

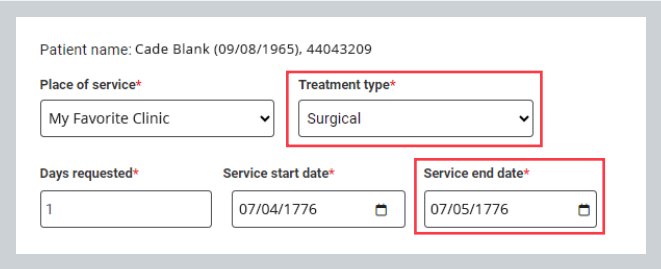
After selecting the appropriate action button (e.g., Prior authorization submission), you must enter required information. Users will be prompted to enter additional information required to complete the request or notification.




**Note:** All search criteria entered as part of the requirement search will auto-populate within the form.

As shown here, users will be required to select a **Treatment type** from a drop-down list based on the chosen **Place of service.**

The **Service end date** can be entered by either selecting the calendar, navigating to and selecting the correct date or by typing the date directly in the field using the MM/DD/YYYY format.

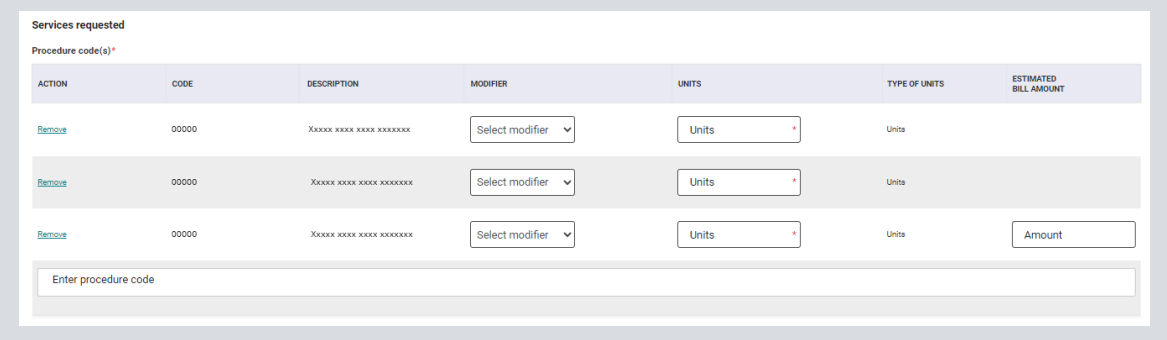



## Submitting a request

# Services required

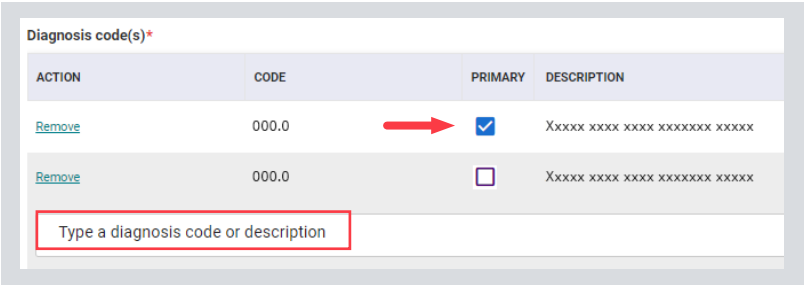
**Procedure Code(s)** – Additional codes not included within the requirement search can be added to the request or notification by using the **Enter procedure code** field.

**Note:** Be sure to enter values for any boxes that are displayed — ex: modifier, units, type of units, estimated bill amount.




**Diagnosis Code(s)** – Additional diagnosis codes can be added by using the free-form text field labeled **Type a diagnosis code or description.**

**Note**: Be sure to use the check box in the Primary column to select the appropriate primary diagnosis code for the request.




Any procedure code or diagnosis code can be deleted from the submission form by clicking **Remove** on the left-hand side of each grid.

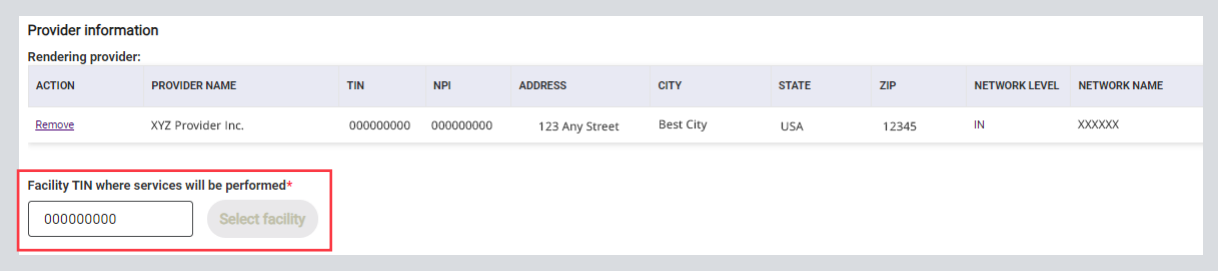
Submitting a request

# Provider information

Within the **Provider information** section, the rendering provider and facility TIN may be required and will be marked with a red asterisk. To search for the rendering provider or facility, enter a valid TIN in the respective search field and choose the **Select physician** or **Select facility** button.

**Note**: The provider search within this section has the same functionality as the search within the initial requirement.

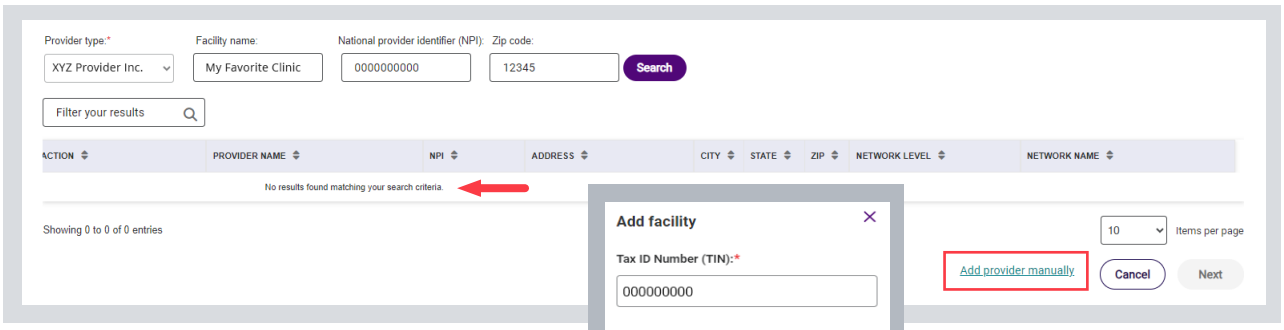
In the example below, the physician was selected as part of the requirement search but the facility where the services will be performed is also required.



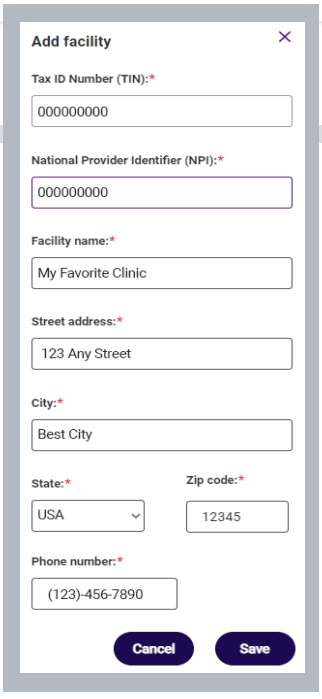

Submitting a request

# Provider Information — Provider not found

If the correct search criteria have been entered, but the desired provider is not included within the search results OR there are no results found (like shown here), select **Add provider manually**.




In the new window, enter all required information (as indicated with an asterisk) and select **Save**.



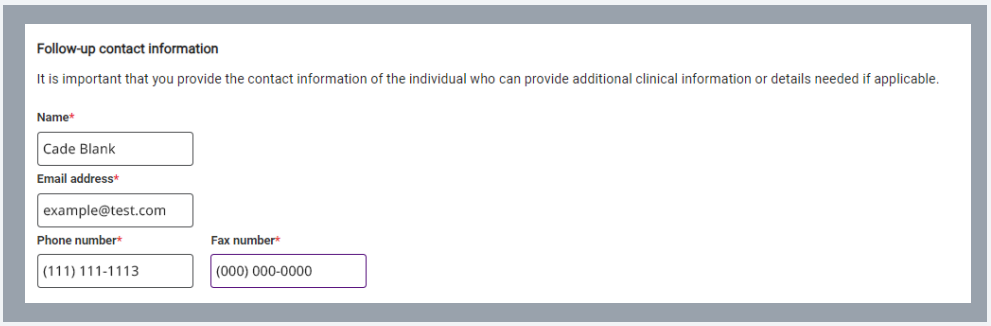
Submitting a request

# Follow-up contact information

In the **Follow-up contact information** section, fill out the required fields for the individual who can provide additional clinical information or details if needed.

**Note:** All fields are required.

- Name
- Email address
- Phone number
- Fax number



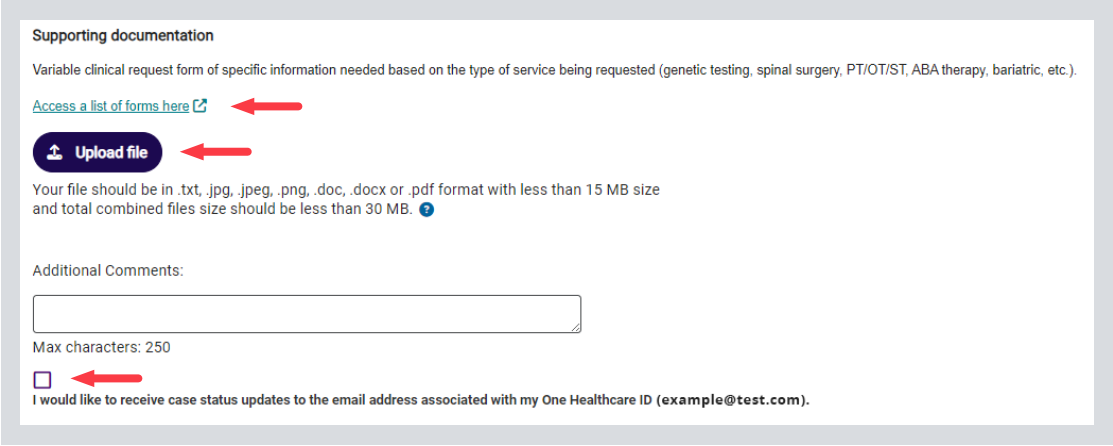

Submitting a request

# Supporting documentation

Clinical information related to the request should be entered in the **Supporting documentation** section. This can be done by selecting the **Upload file** button to attach an existing document or by entering free-form text in the Additional comments field.

**Note**: Users can access provider forms by clicking **Access a list of forms here**.

Check the box at the bottom of the screen if you would like to receive case status updates via the email address associated with your One Healthcare ID.

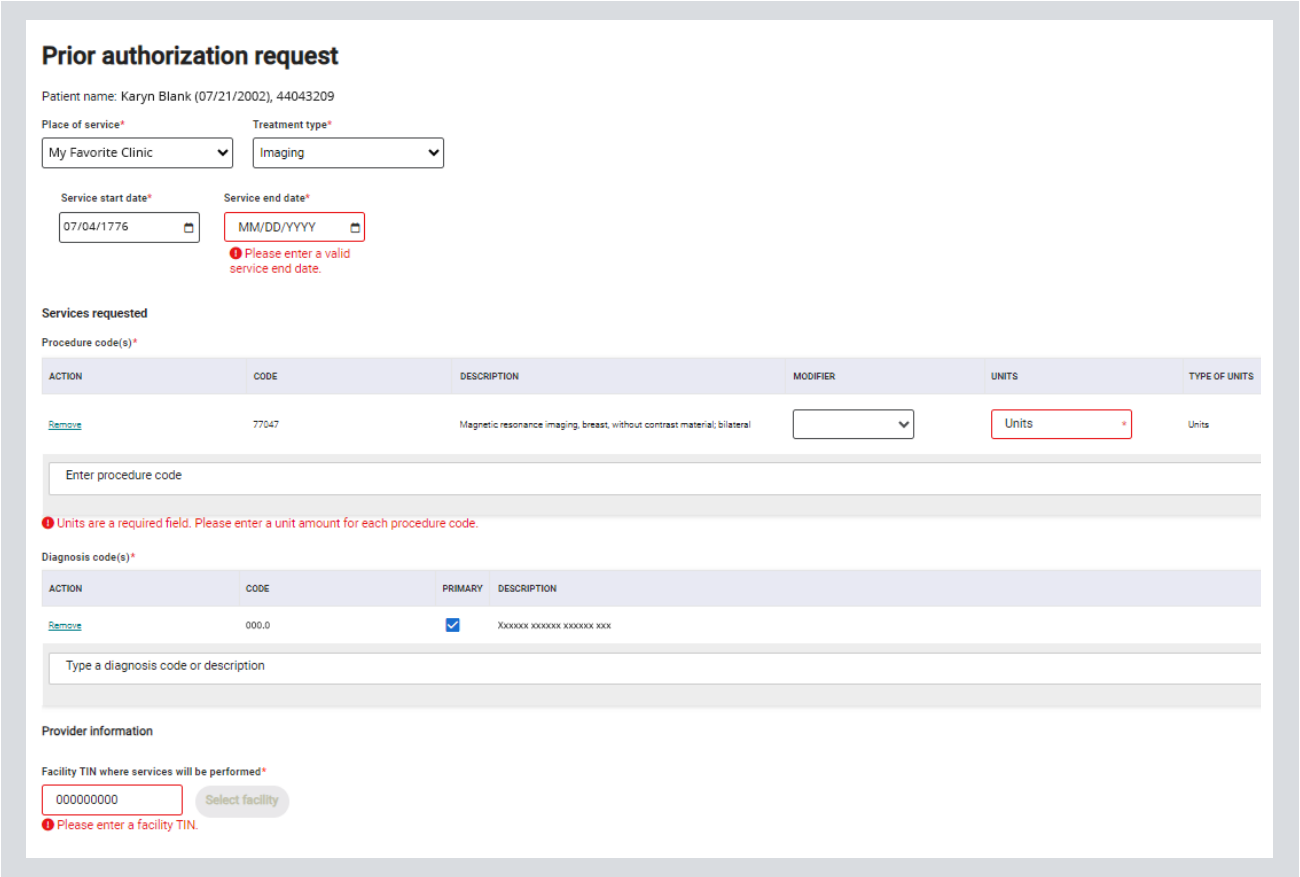


# Submitting

At the bottom of the submission form, users can select one of three action buttons:

- Cancel
- Save and finish later
- Submit

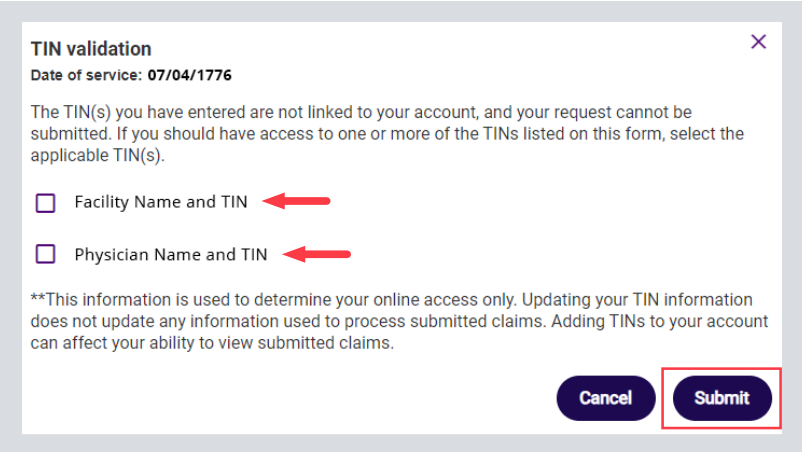
**Note**: When users select **Submit**, red error messaging may appear on the screen to identify missing or incorrect entries. The request cannot be submitted until all errors have been corrected.



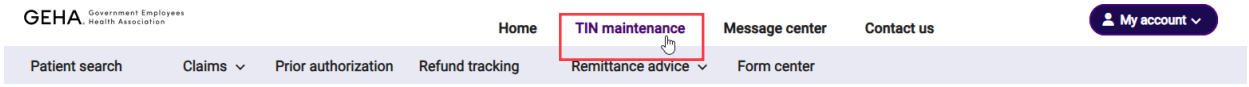
## Submitting a request

# TIN validation

After selecting **Submit** on the submission form, users may see the following window. This usually happens when a provider was manually added and is not yet associated with an existing provider account. Simply select the TIN that is associated with your account and select **Submit** to continue with the submission request.




**Note**: A new TIN can permanently be added to your provider profile by clicking **TIN maintenance** from the main navigation.

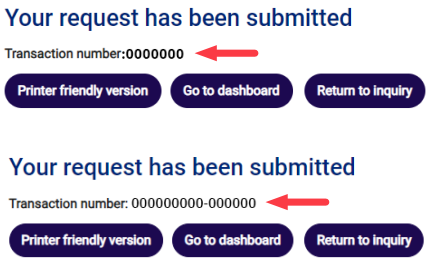



## Submitting a request

# Transaction number

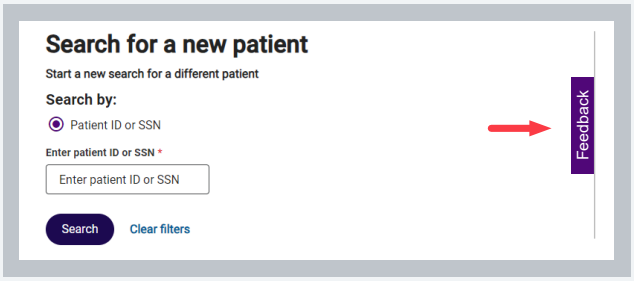
Submitting a request will generate a transaction number in one of two formats, as shown here.

It is important to keep this number for your records. It will be needed to retrieve or modify the request.




# Provider surveys

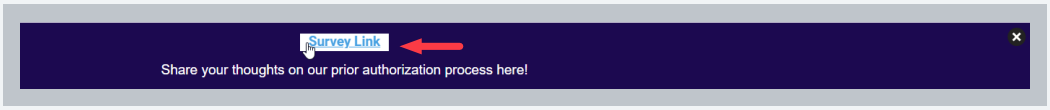
To provide feedback about the overall provider portal experience, select the **Feedback tab** visible on any screen within the portal, as seen below. You will be prompted to answer a few general questions.




## Provider surveys

# Prior authorization process survey

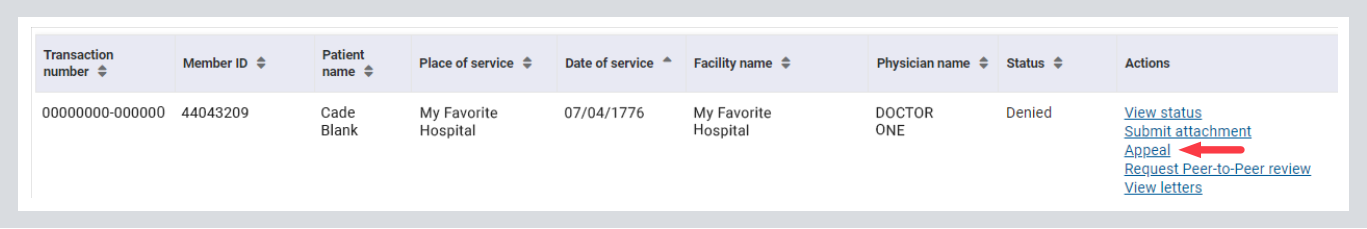
Select the **Survey Link** at the bottom of the submission confirmation screen to provide feedback about the prior authorization process.



Additional services

# How to submit a pre-service appeal request

In the **Action** column, you can select the **Appeal** link to navigate to the Appeal request

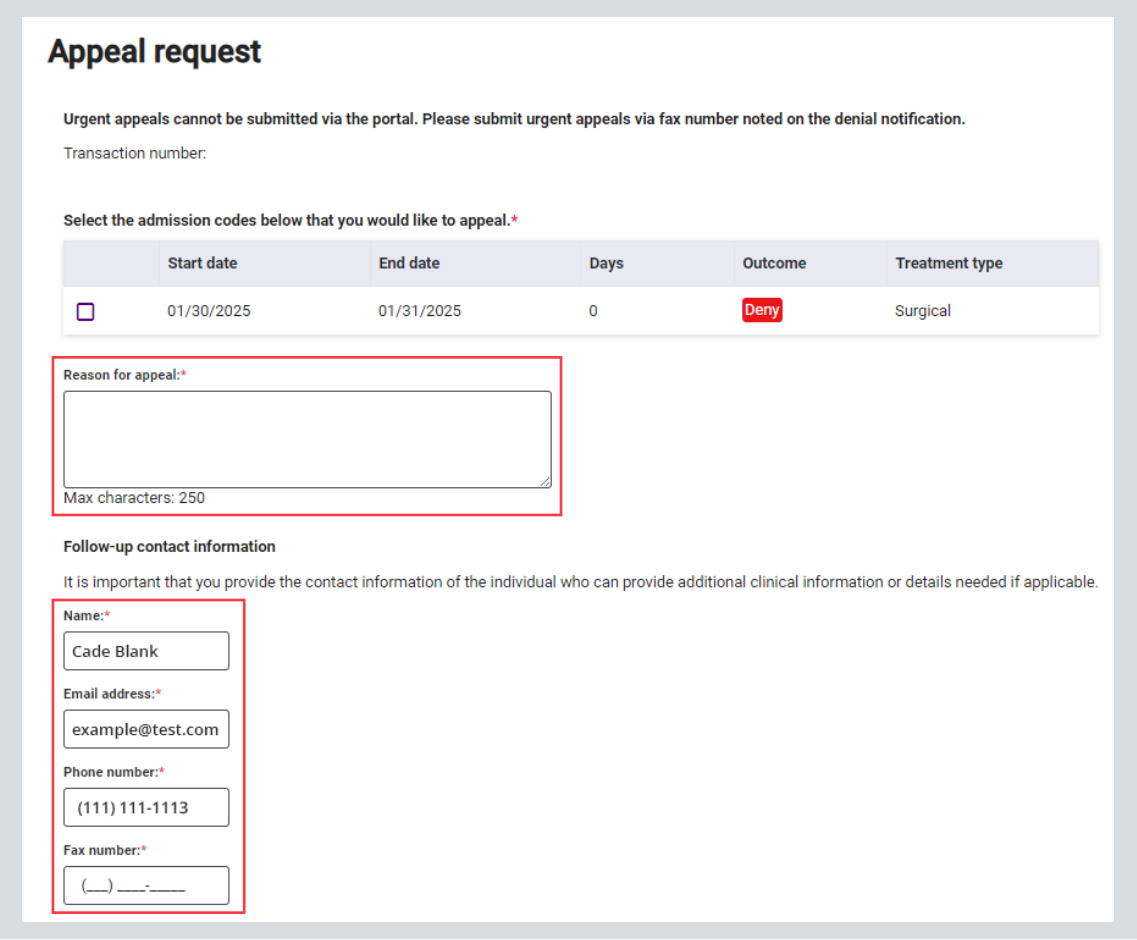


| Transaction number | Member ID | Patient name | Place of service | Date of service | Facility name | Physician name | Status | Actions |
|---|---|---|---|---|---|---|---|---|
| 00000000-000000 | 44043209 | Cade Blank | My Favorite Hospital | 07/04/1776 | My Favorite Hospital | DOCTOR ONE | Denied | View status<br>Submit attachment<br>Appeal<br>Request Peer-to-Peer review<br>View letters |

On the next screen, select the code(s) to be included in the appeal request by selecting the check box next to each line. Then include information related to the appeal request within the **Reason for Appeal** free-form text box.

**Note**: There will be options for uploading supporting clinical documentation further down in the form.

In the **Follow-up contact information** section, fill out the required fields for the individual who can provide additional clinical information or details if needed.



## Appeal request

**Urgent appeals cannot be submitted via the portal. Please submit urgent appeals via fax number noted on the denial notification.**

Transaction number:

**Select the admission codes below that you would like to appeal.***

| | Start date | End date | Days | Outcome | Treatment type |
|---|---|---|---|---|---|
| ☐ | 01/30/2025 | 01/31/2025 | 0 | Deny | Surgical |

**Reason for appeal:***

Max characters: 250

**Follow-up contact information**

It is important that you provide the contact information of the individual who can provide additional clinical information or details needed if applicable.

**Name:***

Cade Blank

**Email address:***

example@test.com

**Phone number:***

(111) 111-1113

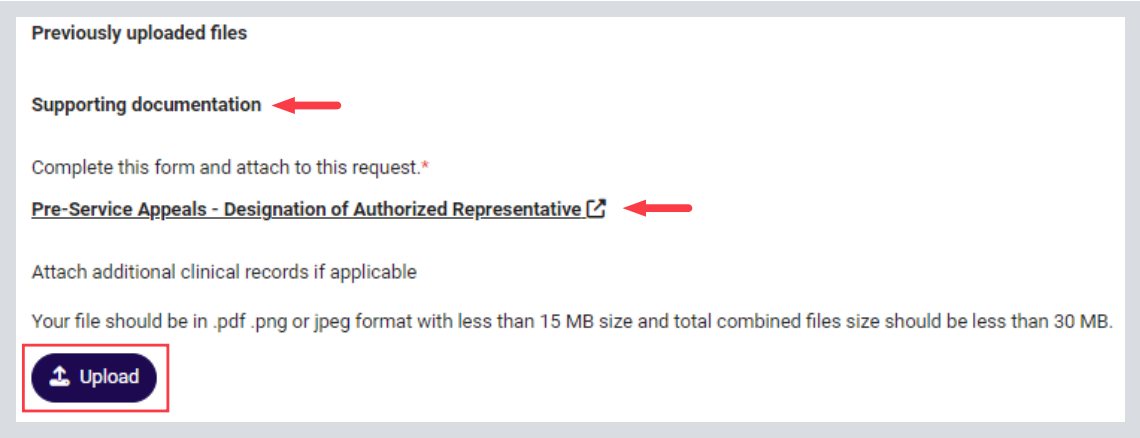
**Fax number:***

(___) ___-____

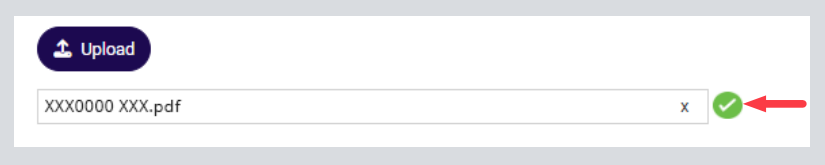
Additional services

# Supporting documentation

The **Pre-Service Appeals-Designation of Authorized Representative** form is required to process the appeal request. It can be accessed via the link shown here. The completed form, along with any other clinical documentation, can be attached to the request by using the **Upload** button on the form.



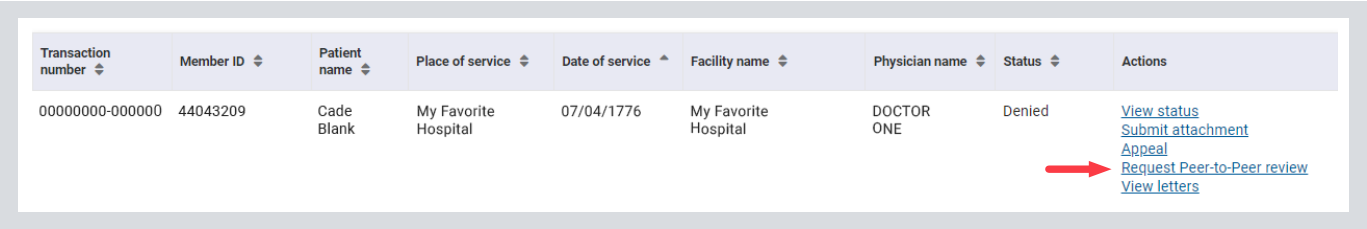

A green check mark will appear to indicate that a file has successfully been uploaded to the request. When all information and supporting documentation have been entered in the form, select the **Submit** button.



Additional services

# How to submit a peer-to-peer request

In the **Action** column, you can select the **Request Peer-to-Peer review** link to navigate to the request form.

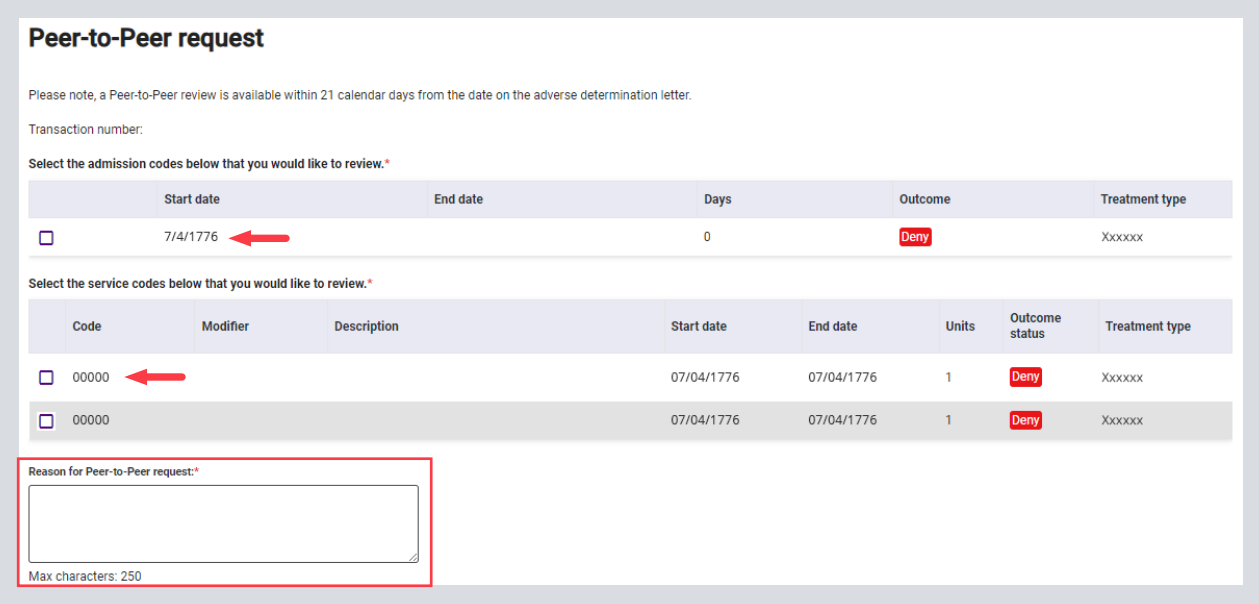


| Transaction number | Member ID | Patient name | Place of service | Date of service | Facility name | Physician name | Status | Actions |
|---|---|---|---|---|---|---|---|---|
| 00000000-000000 | 44043209 | Cade Blank | My Favorite Hospital | 07/04/1776 | My Favorite Hospital | DOCTOR ONE | Denied | View status<br>Submit attachment<br>Appeal<br>Request Peer-to-Peer review<br>View letters |

On the next screen, select the admission code(s) and service code(s) to be included in the appeal request by selecting the check box next to each line.

Then include information related to the appeal request within the **Reason for Peer-to-Peer request** free-form text box.

**Note**: There will be options for uploading supporting clinical documentation further down in the form.



**Peer-to-Peer request**

Please note, a Peer-to-Peer review is available within 21 calendar days from the date on the adverse determination letter.

Transaction number:

**Select the admission codes below that you would like to review.***

| | Start date | End date | Days | Outcome | Treatment type |
|---|---|---|---|---|---|
| ☐ | 7/4/1776 | | 0 | Deny | Xxxxxx |

**Select the service codes below that you would like to review.***

| | Code | Modifier | Description | Start date | End date | Units | Outcome status | Treatment type |
|---|---|---|---|---|---|---|---|---|
| ☐ | 00000 | | | 07/04/1776 | 07/04/1776 | 1 | Deny | Xxxxxx |
| ☐ | 00000 | | | 07/04/1776 | 07/04/1776 | 1 | Deny | Xxxxxx |

**Reason for Peer-to-Peer request:***

Max characters: 250

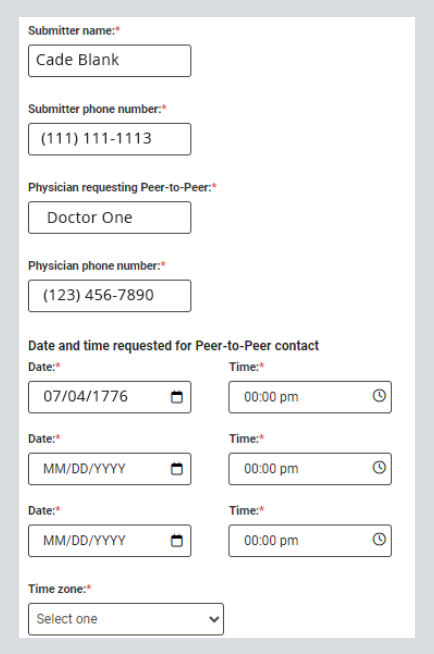
Additional services

# Contact information

Within the **Submitter** fields, enter the name and contact number for the person who is filling out the **Peer-to-Peer request** form.

In the **Physician requesting Peer-to-Peer** section, enter the name and phone number for the physician who will participate in the peer-to-peer discussion.

Further down in the form, users are required to enter three different dates and times that are preferable for contact within the **Date and time requested for Peer-to-Peer contact** section. Time zone is also a required field.



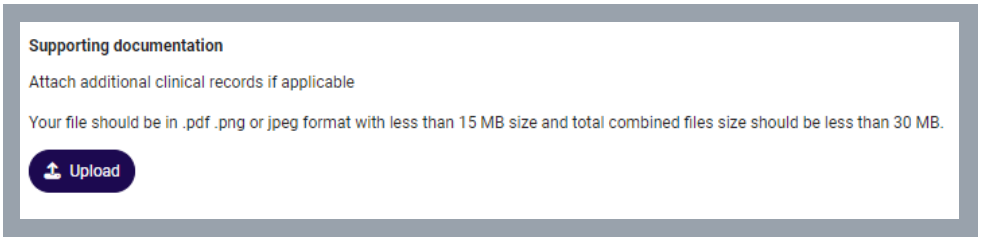

Additional services

# Supporting documentation

Any relevant clinical documentation can be attached to the request by using the **Upload** button on the form within the **Supporting documentation** section.

A green check mark will appear to indicate that a file has successfully been uploaded to the request.

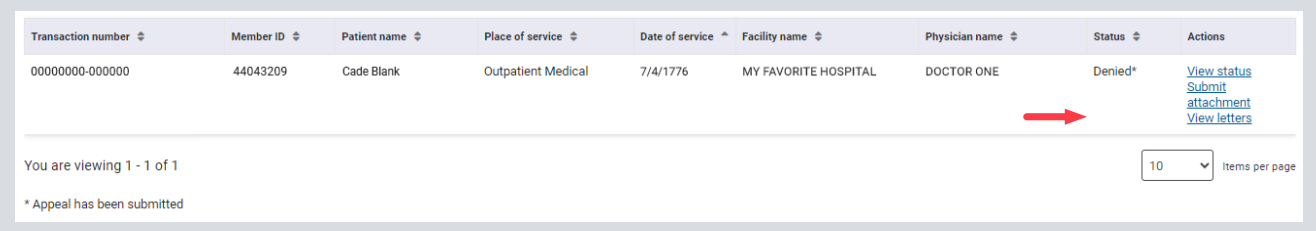
When all information and supporting documentation have been entered in the form, select the **Submit** button.




Additional services

# How to identify a case with an existing pre-service appeal or peer-to-peer request

As seen in the screenshot below, an asterisk in the Status column of the Dashboard indicates that a request has already been submitted for the case.



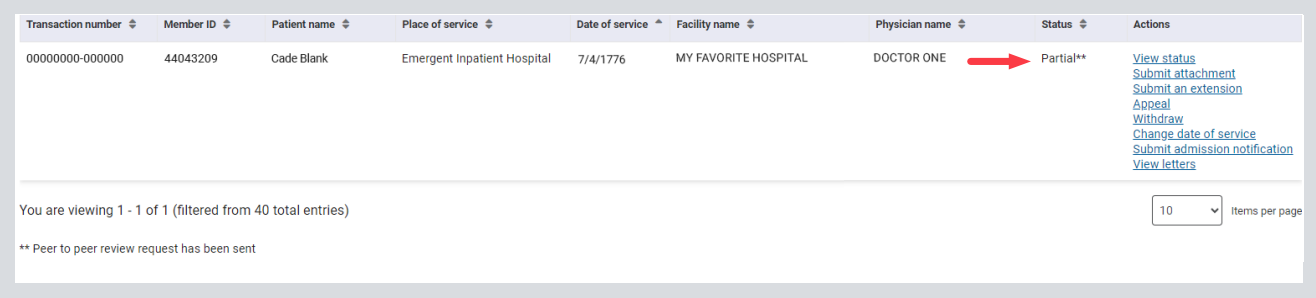
| Transaction number | Member ID | Patient name | Place of service | Date of service | Facility name | Physician name | Status | Actions |
|---|---|---|---|---|---|---|---|---|
| 00000000-000000 | 44043209 | Cade Blank | Outpatient Medical | 7/4/1776 | MY FAVORITE HOSPITAL | DOCTOR ONE | Denied* | View status<br>Submit attachment<br>View letters |

You are viewing 1 - 1 of 1

10 Items per page

* Appeal has been submitted

Two asterisks indicate a peer-to-peer request has been submitted.



| Transaction number | Member ID | Patient name | Place of service | Date of service | Facility name | Physician name | Status | Actions |
|---|---|---|---|---|---|---|---|---|
| 00000000-000000 | 44043209 | Cade Blank | Emergent Inpatient Hospital | 7/4/1776 | MY FAVORITE HOSPITAL | DOCTOR ONE | Partial** | View status<br>Submit attachment<br>Submit an extension<br>Appeal<br>Withdraw<br>Change date of service<br>Submit admission notification<br>View letters |

You are viewing 1 - 1 of 1 (filtered from 40 total entries)

10 Items per page

** Peer to peer review request has been sent

**Looking for additional resources?** Visit geha.com/resource-center/provider-resources

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